Massachusetts Department of Mental Retardation

HEALTH CARE PRACTITIONER (HCP) ENCOUNTER FORM

To be completed by DMR provider.

Name:	**Date and Time of Appointment:** **Name of Health Care Practitioner:**
Allergies:	
Reason for Visit/Symptoms:	

The following section to be completed by health care practitioner.

Results/Diagnosis:

Tests/Treatment Ordered:

New Medications Ordered/Medication Order Change*:

Name	Dose	Frequency	Route	Reason Prescribed	Special Instructions

Follow-up for this problem: **Date/Time:**

Follow-up for other problem(s) identified at this visit: **Date/Time:**
Explain:

If vital signs are indicated, please give parameters and when to call the health care practitioner.

Health Care Practitioner signature*:_____ **Print name:** _____

To be completed by DMR provider.

Staff Follow-up:
☐ **Yes** ☐ **No** ☐ **N/A** **Transcribed orders to med log**

Posted	Date	Time	Verified	Date	Time
Provider Staff Signature			Provider Staff Signature		

☐ **Yes** ☐ **No** ☐ **N/A** **Communicated results of visit to co-workers/supervisor**
☐ **Yes** ☐ **No** ☐ **N/A** **Picked-up pharmacy/medication/treatment forms**
☐ **Yes** ☐ **No** ☐ **N/A** **Notified Day Program of any medication changes**
☐ **Yes** ☐ **No** ☐ **N/A** **Guardian/health care agent/family notified**
☐ **Yes** ☐ **No** ☐ **N/A** **Consultation arranged**
☐ **Yes** ☐ **No** ☐ **N/A** **Completed lab/X-ray** **Date** _____
☐ **Yes** ☐ **No** ☐ **N/A** **Scheduled lab/X-ray** **Date** _____

Staff Signature (Person accompanying patient):_____

* DMR MAP regulations require physician's order in addition to prescription